Sofia R. Friedberg, RN, LMHC, NCC, CCMHC
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INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with___________________☐ primary insurance ☐ secondary insurance

Insurance ID ____________________ Group ID_____________________SS # ________________________

and I assign directly to Sofia R. Friedberg, RN, LMHC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Sofia R. Friedberg, RN, LMHC may use my health care information and may disclose such information to the above named Insurance Company/Companies and their agents for the purpose of determining insurance benefits and obtaining payment for services. This consent will end when my current treatment is completed.

Patient's Name:____________________________________ Date:____________________

Patient's Signature: ________________________________ Relation to Insured: ________________________

Name of Policyholder (if it is not you):____

Date of Birth:_________________________ Telephone:_________________________________

Address: ____

City/State:__________________________________ Zip:__________________